This form may be completed online, printed and mailed to the address listed below.

Nebraska Department of Health & Human Services
Regulation & Licensure, Credentialing Division
PO Box 94986
Lincoln, NE 68509-4986
402-471-4364 or fax 402-471-1066

Affidavit of Not Providing Services/Providing Services

The records of the Credentialing Division of the Department of HHS Regulation & Licensure indicate that you may not be properly registered or authorized to provide services as a Medication Aide under the Medication Aide Act. Being properly registered or authorized includes having an active registration in the appropriate category for where you are providing services or being within the allowed 30 days after you have met all of the requirements for registration. (*Please note that if you are providing services in an assisted living facility, an ICF-MR or a nursing home, you must have a current registration as a Medication Aide-40 Hour. For all other types of licensed facilities, you must have a current registration as a Medication Aide, Medication Aide-20 Hour or Medication Aide 40-Hour.)

You must complete the following.

_____ I **have not** provided services as a Medication Aide in Nebraska without being properly registered or authorized.

_____ I **have** provided services as a Medication Aide in Nebraska without being properly registered or authorized. The actual number of partial or whole days that I provided services is _____.

If you have provided services as a Medication Aide without proper authority, you will be required to pay an administrative penalty fee of $10.00 for each day you provided services up to a maximum of $1000. You may enclose any penalty due with this form. If you do not enclose the penalty you will receive a Notice of Administrative Assessment and you will be required to pay the penalty at that time.

Employer Information:

_____
Name

_____
Address

_____
Telephone Number

_____
Dates of Employment as a Medication Aide

Personal Information:

Print Your Name:_____

Your Medication Aide Registration #: _____Daytime Phone Number: _____

Affidavit:

State of _____ County of _____, I _____ being duly sworn, say that I am the person referred to in this affidavit, that the statements herein contained are true to the best of my knowledge and belief, and that I have read and understand the affidavit.

_____ _____
Legal Signature of Applicant Date